

Tennessee Valley Authority, Post Office Box 2000, Spring City, Tennessee 37381

July 18, 2019 WBL-19-037

10 CFR 50.73

ATTN: Document Control Desk U.S. Nuclear Regulatory Commission Washington, D.C. 20555-0001

> Watts Bar Nuclear Plant, Unit 2 Facility Operating License No. NPF-96 NRC Docket No. 50-391

Subject: Licensee Event Report 391/2019-001-00, Manual Reactor Trip Due to Main Feedwater Regulating Valve Failing Closed

This submittal provides Licensee Event Report (LER) 391/2019-001-00. This LER provides details concerning a manual plant trip as a result of a main feedwater regulating valve failing closed. This condition is being reported as a safety system actuation of the reactor protection system and the auxiliary feedwater system in accordance with 10 CFR 50.73(a)(2)(iv)(A).

There are no regulatory commitments contained in this letter. Please direct any questions concerning this matter to Tony Brown, WBN Licensing Manager, at (423) 365-7720.

Respectfully,

Anthony L. Williams IV Site Vice President Watts Bar Nuclear Plant

Enclosure cc: See Page 2

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cc (Enclosure):

NRC Regional Administrator - Region II NRC Senior Resident Inspector - Watts Bar Nuclear Plant



LICENSEE EVENT REPORT (LER)

Estimated burden per response to comply with this mandatory collection request. 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Information Services Branch (T-2 F43), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001,or by e-mail to Infocollects. Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to Impose an Information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

| 1. Facil | ity Name |) | | | | | | | 2. Do | ock | et Number | | 3. Pa | ge | | | |
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| Watts Bar Nuclear Plant, Unit 2 | | | | | | 050 | 000 | 00391 1 | | | OF 5 | | | | | | |
| 4. Title Manu | ıal Rea | ctor Tri _l | Due to | Main | Feedwa | ater R | tegulatir | ng Valv | e Failin | ıg C | Closed | • | | | | · | |
| 5. | Event Da | ite | 6 | . LER N | lumber | | 7. | Report | Date | Ī | | 8. Other | Facilit | ties Invol | ved | | |
| Month | Day | Year | Year Sequential Number | | | Rev | | | Year | | Facility Name N/A | | | | Docket Number 05000 | | |
| 05 | 22 | 2019 | 2019 | - 00 ⁻ | 1 - | 00 | 07 | 18 | 2019 | 9 | Facility Name NA | | | | Docket Number 05000 | | |
| 9. Op | erating I | Mode | | 11. 1 | his Repo | ort is S | ubmitted | Pursua | nt to the | Re | quirements of | 10 CFR §: | (Che | ck all tha | t apply | <i>)</i> | |
| | | | 2 0. | 2201(b) |) | | 20.2 | 203(a)(3 | 3)(i) | | 50.73(a) |)(2)(ii)(A) | | <u> </u> | .73(a)(| 2)(v | iii)(A) |
| | _ | | 2 0. | 20.2201(d) | | | 20.2203(a)(3)(| | | | 50.73(a) |)(2)(ii)(B) | 50.73(a)(2)(viii)(B) | | | | iii)(B) |
| | 1 | | 20.2203(a)(1) | | | 20.2203(a)(4) | | | !) | | 50.73(a) |)(2)(iii) | 50.73(a)(2)(ix)(A) | | | | (A) |
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| | | | 20.2203(a)(2)(iv) | | | 50.46(a)(3)(ii) | | | i) | | 50.73(a)(2)(v)(C) | | | 73.77(a)(1) | | | |
| | 95 | | 20.2203(a)(2)(v) | | | 50.73(a)(2)(i)(A) | | |)(A) | | 50.73(a)(2)(v)(D) | | | 73.77(a)(2)(i) | | | |
| | | | 20.2203(a)(2)(vi) | | | 50.73(a)(2)(i)(B) | | |)(B) | | 50.73(a) |)(2)(vii) | | 73.77(a)(2)(ii) | | |) |
| | | | | | | 50.73(a)(2)(i)(C) | | | | OTHER Specify in Abst | | | bstract below or in NRC Form 366A | | | | |
| | | | | | | 12 | 2. Licens | ee Cont | act for th | is L | ER | | | | | | |
| Licensee C Dean E | | icensin. | g Engine | eer | | | | | | | | Tei | lephone | Number (Ir (423) 4 | | | de) |
| | | | 1 | 3. Com | plete On | e Line | for each | Compo | nent Fail | ure | Described in t | his Repor | t | | | | |
| Cause | | System | Comp | onent | Manufact | urer R | eportable to | ICES | Cause | | System | Compone | ent | Manufactu | rer Re | porta | able to ICES |
| В | | SJ | FC | CV | FISHE | R | Υ | | | | | | | | | | |
| | | 14. Sup | plementa | l Repor | t Expect | ed | | | 45 5 | | atad Cubadasi | on Data | | Month | Day | $oldsymbol{\mathbb{I}}$ | Year |
| ☐ Ye | s (If yes, | complete | e 15. Expe | cted Su | ubmission | Date) 🛛 No | | | 15. E | 15. Expected Submission Date | | | | N/A | N/A | | N/A |
| On Ma tripped during system design This er contro diaphr | y 22, 2 I due to power n actual ed. vent wall of the agm w | 2019, a o a faile ascen ated as as caus as caus as defe | ure of the sion foldesign sed by MFRV. ective d | Eastene Stellowing ed. A a defe | ern Day eam Ge g a refu Il Cont ective a tributing its repl | light enera ueling rol ar actual g to the | Time (I tor (SG g outag nd Shu tor diap his eve nent. C | EDT), 6) num e. Cor tdown hragn nt, per orrect | ber 2 M neurren rods fu n that le rsonnel ive acti | Mai nt w ully ed I m on: | r Nuclear P in Feedwate vith the read r inserted. A to prematur issed an op s include re ad installatio | er Regu tor trip, Il safety re failure portunii placeme | the and ty to | g Valve Auxiliar tems re d subse identify | e (MF ey Fee espon equer | RV edv ded | vater d as |
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LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Information Services Branch (T-2 F43), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by e-mail to Infocollects. Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

PPROVED BY OMB: NO. 3150-0104

| 1. FACILITY NAME | 2. DOCKET NUMBER | 3. LER NUMBER | | | | | |
|---------------------------------|------------------|---------------|----------------------|------------|--|--|--|
| Watts Bar Nuclear Plant, Unit 2 | 05000391 | YEAR | SEQUENTIAL NUMBER | REV NO. | | | |
| | 3333331 | 2019 | - 001 | - 00 | | | |

NARRATIVE

I. Plant Operating Conditions Before the Event

Watts Bar Nuclear Plant (WBN) Unit 2 was at 95 percent rated thermal power (RTP). Unit 1 was unaffected by this event.

II. Description of Event

A. Event Summary

On May 22, 2019, at 0233 Eastern Daylight Time (EDT), Watts Bar Nuclear Plant Unit 2 reactor was manually tripped due to a failure of the Steam Generator (SG) number 2 Main Feedwater Regulating Valve (MFRV){EIIS:FCV} during power ascension following a refueling outage. Concurrent with the reactor trip, the Auxiliary Feedwater system {EIIS:BA} actuated as designed. All Control and Shutdown rods fully inserted. All safety systems responded as designed.

This event is being reported to the Nuclear Regulatory Commission (NRC) under 10 CFR 50.73(a)(2)(iv)(A) as a safety system actuation of the Reactor Protection System (RPS) and the Auxiliary Feedwater (AFW) system.

B. Status of structures, components, or systems that were inoperable at the start of the event and that contributed to the event

No inoperable structures, systems, or components contributed to this condition.

C. Dates and approximate times of occurrences

| <u>Date</u> | <u>Time</u> | <u>Event</u> |
|-------------|-------------|--|
| | (EDT) | |
| 5/22/19 | 0231 | Entered 2-AOI-16, Loss of Normal Feedwater, due to SG 2 |
| | | MFRV failing closed. |
| 5/22/19 | 0233 | Unit 2 Reactor manually tripped due to uncontrolled lowering |
| | | level in SG 2. |
| 5/22/19 | 0234 | Entered 2-E-0, Reactor Trip or Safety Injection |
| 5/22/19 | 0236 | Entered 2-ES-0.1, Reactor Trip Response |
| 5/22/19 | 0314 | Entered 2-GO-5, Unit Shutdown from 30 percent Reactor Power |
| | | to Hot Standby |
| | | • |

D. Manufacturer and model number of each component that failed during the event

The component that failed was the diaphragm of a Fisher Type SS-137 Reverse-Action Diaphragm actuator, diaphragm part number 2R6376X0082.

U.S. NUCLEAR REGULATORY COMMISSION

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E. Other systems or secondary functions affected

No other systems or secondary functions were affected.

- F. Method of discovery of each component or system failure or procedural error
 - The component failure became apparent when the SG 2 MFRV failed closed.
- G. Failure mode, mechanism, and effect of each failed component

The MFRV closed due to a failed actuator diaphragm.

H. Operator actions

Upon identifying the SG 2 MFRV had failed closed, operations personnel manually tripped the plant and followed operations procedures in response to a plant trip.

I. Automatically and manually initiated safety system responses

The plant was manually tripped when the SG 2 MFRV failed closed.

III. Cause of the Event

A. Cause of each component or system failure or personnel error

The SG 2 MFRV failed closed as a result of the installation of a defective valve actuator diaphragm.

B. Cause(s) and circumstances for each human performance related root cause

The personnel performing maintenance on the SG 2 MFRV missed an opportunity to identify the diaphragm they replaced was defective.

IV. Analysis of the Event

The SG MFRVs control flow to the steam generators to maintain level within a desired operating band. The isolation of a single MFRV causes the level in the associated SG to rapidly lower. On May 22, 2019 when SG 2 MFRV failed closed, SG level lowered and operations personnel manually tripped the reactor prior to reaching the SG level automatic trip setpoint.

Investigation revealed the diaphragm in the MFRV that had been replaced during the prior unit outage had torn. This failure was due to a defective diaphragm. Additionally, maintenance personnel did not identify the defect prior to installation.

NRC FORM 366A (04-2018) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

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PPROVED BY OMB: NO. 3150-0104 EXPIRES: 03/31/2020

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V. Assessment of Safety Consequences

This event closely matches and is bounded by the Loss of Normal Feedwater event described in the Updated Final Safety Analysis Report (UFSAR). A probabilistic risk review of this event shows the risk from this trip is very small.

A. Availability of systems or components that could have performed the same function as the components and systems that failed during the event

Not applicable.

B. For events that occurred when the reactor was shut down, availability of systems or components needed to shutdown the reactor and maintain safe shutdown conditions, remove residual heat, control the release of radioactive material, or mitigate the consequences of an accident

Not applicable.

C. For failure that rendered a train of a safety system inoperable, an estimate of the elapsed time from the discovery of the failure until the train was returned to service

Not applicable.

VI. Corrective Actions

These events were entered into the Tennessee Valley Authority (TVA) Corrective Action Program and are being tracked under Condition Report (CR) 1518719.

A. Immediate Corrective Actions

The valve diaphragm was replaced with a non-defective diaphragm and the plant was returned to operation.

B. Corrective Actions to Prevent Recurrence or to reduce probability of similar events occurring in the future

Corrective actions include revising the maintenance instructions for diaphragm inspection requirements.

VII. Previous Similar Events at the Same Site

LER 391/2017-002-00 submitted on May 12, 2017, documents an event where the reactor was manually tripped as a result of a secondary plant transient. This event resulted when scaffold

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

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crews inadvertently depressed the local trip button for the 2A Hotwell pump, which resulted in the secondary system transient.

LER 391/2016-007-00 submitted on October 21, 2016 documents a manual reactor trip due to a loss of main feedwater. The loss of main feedwater was due to a leak on a hydraulic fitting associated with the Main Feedwater Pump Turbine High Pressure Governor valve, resulting in the valve going partially closed. Subsequent investigation determined the leak to be caused by the installation of incompatible fittings associated with the governor valve that occurred during plant construction.

The previous similar events have different direct causes than this event.

VIII. Additional Information

There is no additional information.

IX. Commitments

There are no new commitments.